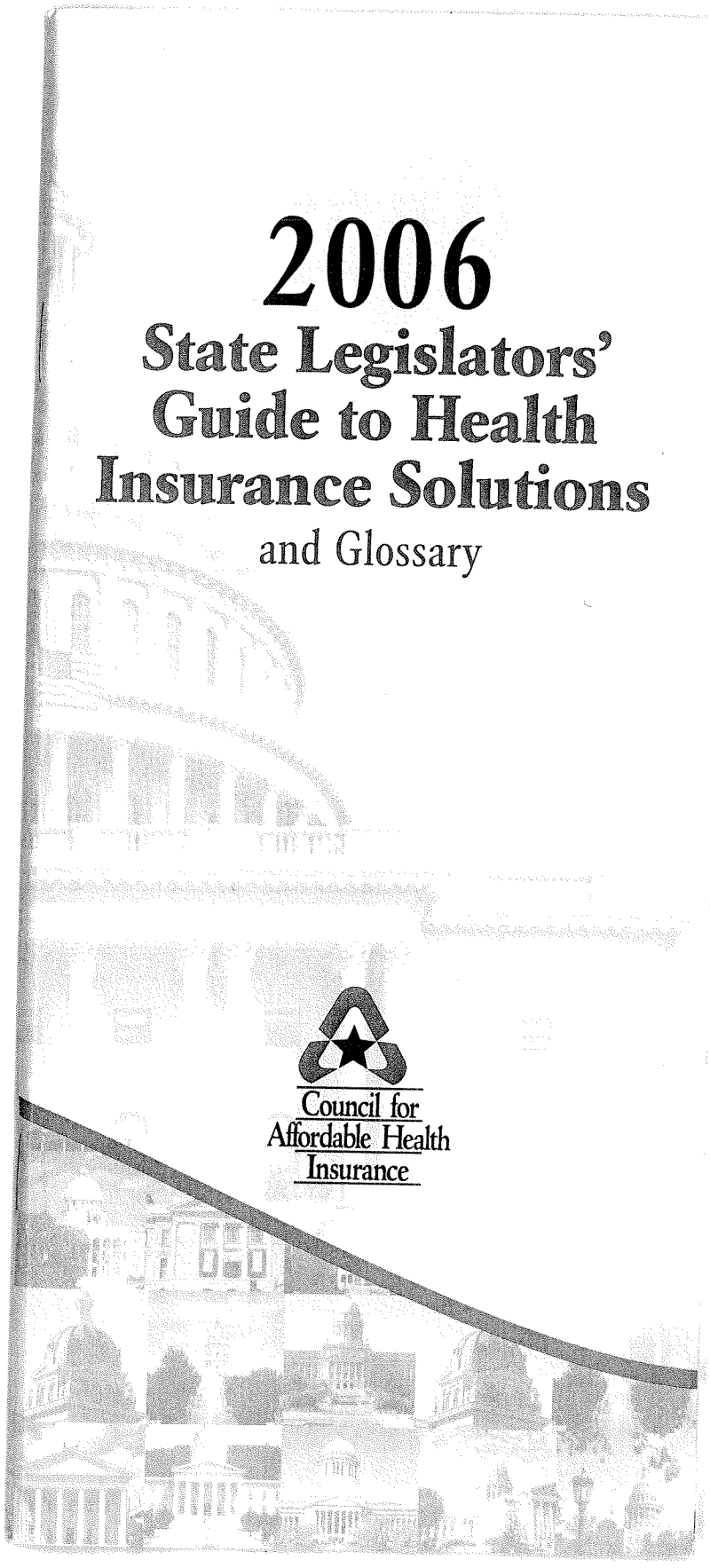
2006
State Legislators' Guide to Health Insurance Solutions
and Glossary



Council for Affordable Health Insurance

The Council for Affordable Health Insurance (CAHI) is a research and advocacy association of insurance carriers active in the individual, small group, HSA and senior markets. CAHI's membership includes health insurance companies, small businesses, physicians, actuaries and insurance brokers. Since 1992, CAHI has been an advocate for market-oriented solutions to the problems in America's health care system.

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The good news this past year is that we have seen health insurance costs start to moderate. MilliманUSA's survey of HMO and PPO insurance carriers shows increases of 8%—a marked improvement over the double-digit increases of the past few years. Better still, the survey also found that high deductible PPO plans increased only by 1%.

While an 8% increase in costs is an improvement, health insurance premiums continue to be unaffordable for many Americans. Not coincidentally, the number of uninsured Americans has also continued to grow, to 45.8 million people in 2005—matching the 15.7% uninsured rate in 2004.

States have also been feeling a budget crunch as desperate people turn to state Medicaid and public health care systems—a problem exacerbated by governors who propose to increase the role of Medicaid. That means state legislators are looking for solutions—now.

Are there things states can do to keep health insurance accessible and premiums affordable?

Are there ways to expand choice and availability of insurance plans? Can a state appropriately regulate the health insurance industry—ensuring consumer protections—without harming the market? Can states solve the problem of the uninsurable?

The answer to all these questions is yes, and this Guide can show you how.

Here you will find many of the issues confronting the health insurance market and its consumers. We have summarized each issue, highlighted actions already taken by states, and offered possible solutions. We have also included a glossary that explains a number of industry terms. We invite you to use this Guide as a starting point for your deliberations and proposals. And call us. We can expand upon the issues and the ways in which our solutions can help you deal with each of them.

Now is the time to act. You have a mandate from your constituencies to tackle health insurance problems. The Council for Affordable Health Insurance exists to help you find solutions. Use this Guide, and use us, too.

For further information contact J.P. Wieske, Director of State Affairs, Council for Affordable Health Insurance (CAHI), at 920-499-8803.

Regulating the Health Insurance Market

Anyone who seeks to understand the health insurance market finds that it is complicated. Even more problematic is that it seems regulation functions much like a balloon—squeeze one end and the other end becomes bigger.

Throughout this Guide we discuss a variety of issues facing policy-makers, including new ways to expand access to affordable health insurance. We also discuss the most important safeguards for consumers.

We believe many consumer protections are vital, but legislators and regulators need to set priorities. Some protections are more important than others. Listed below are what we believe are the most vital consumer protections.

1. **Keeping health insurers solvent**—Consumers have purchased insurance policies for financial protection—a hedge against risk—and insurance companies should be there when needed. Appropriate solvency standards ensure that companies will have the financial means to pay claims when they are due. Financial statements provided by insurers should follow uniform standards and be clear and consistent.

2. **Paying claims appropriately**—Insurers should be obligated to pay *every* penny they owe, but not one penny more. Regulators should review appeals seriously, but understand that the consumer is not always correct—no matter how heartbreaking the story. Insurers have an obligation to pay claims in a timely manner, consistent with a review of all appropriate policy terms and conditions.

3. **Objective health insurance rate review**—An objective review of health insurance premium rates—based on a loss-ratio standard—ensures premiums that both are fair to policyholders and protect the solvency of the health insurer.

4. **Treating policyholders fairly**—Consumers face a host of issues ranging from pre-existing condition limitations and late payment issues to the appeals processes. Consumers should be able to expect that insurers will treat them fairly and consistently and according to the policy terms and provisions.

5. **Eliminating fraud**—Insurance policies contain many provisions that protect consumers and insurers from the costs of fraud. Insurance companies need time and the legal rights to find and eliminate fraud.

Issues Facing State Legislators

Association Group Business

Insurance sold through an association to its members. Also known as "out-of-state" group insurance because the insurer may not be located in the state.

Most associations provide their members with a variety of benefits. For example, the American Automobile Association (AAA) provides its members with towing insurance, travel discounts, travel planning service, access to auto and life insurance, and many other benefits. Association benefits are used, in part, to attract new members to the association. Better benefit packages lead to better retention and increased membership.

As a result, associations spend a great deal of time and effort in designing attractive benefit packages. The packages often include discounts on a variety of services and insurance products—including health insurance. After designing the benefit package with the health insurance company, the association makes the individually underwritten health insurance plans available to all of its members on a non-discriminatory basis.

Not only has association group insurance been valuable to associations, it has proven valuable to consumers as well. While most nonelderly Americans (those under age 65) obtain coverage from their employer, many do not have access to employer-based coverage. Millions of consumers nationwide have turned to the association group market for their health insurance. Association group insurance provides a valuable alternative to the domestic market in a number of states.

In response, statutes and regulations in 46 states guide the advertisement, sale and administration of these insurers and policies. Most states have already passed laws that define the types of groups through which health insurance plans may be sold (including association plans) and the rules governing the groups. The National Association of Insurance Commissioners' "Group Health Insurance Definition and Group Health Insurance Standard Provisions Model Act" also recognizes association group insurance and contains provisions that have been the model for many state laws.

Note: Association group insurance is often confused with Association Health Plan (AHP) legislation being considered in Washington. They are two separate approaches. Associations can already sell insurance if they are using a licensed insurance company to underwrite the policies.

SOLUTIONS: Association group insurance helps lower the cost of providing health insurance and provides a valuable option for millions of Americans without access to employer-based insurance. Association group insurance should continue to be protected from requirements like rate regulation and mandates that will further complicate the sale of these policies and increase costs. Additionally, associations should be permitted to offer health insurance coverage to their members across state lines without having to meet the burdensome filing and approval regulations for every state, so long as the association plan is based in an NAIC-accredited state. States should also reduce unnecessary regulations on both association plans and in-state individual plans.

Business Group of One

Legislation or regulation that states that one person constitutes a "group" for purposes of purchasing health insurance. Usually requires insurers to guarantee issue the policies (i.e., insurance carriers must take all applicants, regardless of their health condition) and charge everybody the same amount (i.e., community rating).

Webster's Dictionary defines "group" as "two or more figures forming a complete unit in a composition." Thus by definition a group of one is impossible. Group policies function differently from those in the individual market, and currently fall under different laws and incur different administrative costs. As a result, there is an additional cost to insuring individuals in the group market, which cost is borne by the small groups

Additional administrative expenses are not the only cost that true small groups are forced to subsidize when a state mandates a group of one. Because the Health Insurance Portability and Accessibility Act (HIPAA) requires guaranteed issue in the small group market, groups of one have the option of choosing the more expensive small group market or purchasing cheaper non-guaranteed issue plans in the individual market. Clearly, individuals who do not meet health insurer standards in the individual market will choose to purchase guaranteed issue coverage as a group of one. This development leads to a problem known as "adverse selection," which means a group of one will tend to be sicker and cost more to insure.

The net result of mandating a group of one is that applicants can game the system, leading to increased administrative and claims costs for the small group market. Over time, they make the small group market unaffordable for many small groups.

SOLUTIONS: Keep the individual and small group markets separate and distinct. They serve two different populations. If a state has conjoined the two, propose legislation that separates them. That will allow both markets to function efficiently and thereby keep health insurance accessible and affordable. In order to solve the problem of the uninsurable, please see our discussion of high-risk pools.

Clean Claims Laws/Prompt Pay Laws

Laws intended to compel health insurers and health plans to be prompt in their reimbursement of health care providers. Clean claims laws generally define what information the insurer or health plan may request in order to process a benefit claim. Prompt pay laws usually define what constitutes a clean claim and specify the amount of time an insurer or health plan has to pay a claim.

Clean claims laws seek to balance the dual obligation of insurance carriers to pay claims both accurately and quickly. While the majority of claims (in most cases more than 50%) are paid electronically in fewer than 10 days, there are a few kinds of claims that may require more scrutiny. Complicated or rare procedures, pre-existing conditions and suspicious looking claims that may be fraudulent may require additional investigations. If carriers do not have the time to appropriately investigate these kinds of claims, they will have to pay them anyway. However, actuarial underwriting is based on accurate claims expectations. If insurers are paying higher claims than they should, higher premiums may result.

Paying inappropriate claims is only part of the problem. Narrow time frames also increase administrative expenses by requiring more staff to process the claims, request refunds from providers who were overpaid, and process appeals from patients whose claims were underpaid.

A number of states have passed restrictive laws, only to find that their solutions have created more problems. For example, Texas passed a restrictive law that required ALL claims be paid within a specified time frame (30 days for electronically submitted claims, 45 days for paper claims) with no exceptions. Instead of appropriately investigating the claim, insurers were required to pay the claims and then try to get any overpayments back from providers.

The law was a disaster. One company that processed more than 45,000 claims over a 20-month period paid all but 17 within the required time. For those 17 late payments (which amounted to .04% of all claims processed) the company was fined $60,000. Insurers' administrative costs began to rise as a result, which began to push up premiums. Clearly, the 100% standard was unworkable.

Texas repealed the law and created a slightly more reasonable 98% time frame. Other states have designed more successful claims payment standards. For example, Mississippi and Florida have established a standard of 95% of submitted claims paid within a certain amount of time of receipt by the insurer. These compromises balance the need for prompt claims payment with insurers' need to appropriately investigate complex claims.

SOLUTIONS: States concerned about delayed reimbursements should adopt the 95% standard to balance health care providers' need to be reimbursed quickly with insurers' need to guarantee that the reimbursements are accurate. Time frames also should allow a limited number of exceptions for claims requiring additional information and should specify how long providers have to send the needed information.

Closed Block

When a group of health insurance policies (also known as a "block") is no longer being sold to new clients in the individual market, it is known as a "closed block."

Individual health insurance is a complicated market and has become very volatile—particularly for smaller carriers. Problems faced by insurers include adverse selection (since individuals can conceal health risks in order be approved), persistency (individuals rarely own their policy for more than a couple of years), and guaranteed issue requirements for those who move from group to individual coverage, required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Insurers also understand that the longer individuals keep their policy, the more costly it will be to cover their health care needs.

To keep prices as low as possible for everyone, insurers have to continually attract new individuals. They do this in a variety of ways. One common way is to create newer plan designs that appeal to ever-changing consumer tastes. Separating the claims experience of the new plans from older plans (creating two separate blocks of policies with two different claims experiences) leads to lower rates on the new plans. If the insurance carrier stops selling new policies for the older block, the block becomes a closed block. While closing a block of policies ensures that the rates of new policies are low, it also can result in an increasing rate for the closed block (because younger and healthier people will no longer be pooled in it). Over time, the closed block will experience more frequent and higher claims, which drives up premiums. Higher premiums, plus people leaving the block for other reasons (e.g., they find other coverage, turn 65 and join Medicare, etc.), means the pool gets smaller and smaller and costs go up (because there are fewer people to share the costs). As a result, opponents of this process believe that it is not fair to have any closed blocks.

However, it is clear that allowing carriers to close blocks keeps overall insurance rates lower for as many as possible. Carriers opening new blocks are able to keep those rates low, attract new business, and decrease the number of uninsured.

The American Academy of Actuaries (AAA) undertook a review of the possible solutions to this issue. It attempted to balance the needs of individuals who were in closed blocks with the need to keep prices as low as possible. Some of the Academy's possible solutions include:

1. **Prefunding**—Requires insurance carriers to raise rates by as much as 45% and defer any profits in order to create a reserve fund to pay for premiums in later policy years. By substantially increasing rates in early years, the rates in later years remain more stable. However, a substantial increase in initial rates has a chilling effect on sales and increases the number of uninsured.

2. **Individual medical pool**—Creates a state-run pool for individuals whose insurance rates have become unaffordable. Similar in design to a high-risk pool, it would allow an individual to move to the pool only after a specified period of time, or when rates exceed a specified percentage.

3. **Rate band**—Creates a relationship between the highest and lowest rates charged for similar plans. In practice, it means the difference between the most expensive rate and least expensive rate is limited—ensuring that increases in the closed block plan are limited. However, a rate band that is too narrow would result in rate increases similar to those in prefunding. (See below for the full discussion of rate bands.)

4. **Pooling**—This solution requires carriers to combine (or pool) the experience of all their blocks after a specified period of time. Pooling is easy for the carriers to administer, but if the pooling time frame is too short (e.g., only one year), insurers will have a difficult time selling new policies. On the other hand, pooling time frames of over five years guarantee that premiums remain affordable, and continue to attract new insured persons.

SOLUTIONS: As can be seen above, the closed block issue is very complicated. The AAA study provided no evidence that any proposed solution would actually improve the uninsured rate. The current closed-block approach appears to provide the best solution to the problem (providing both the lowest rates and the highest number of insured persons). Other solutions should only be considered with broad limits (i.e. wider rate bands and longer pooling time frames).

Community Rating

Requires an insurer to charge the same price to everyone in a "community," or pool, regardless of the differences in risk the individuals present. Age, lifestyle, health and gender factors may not be used to determine rates. In economic terms, it is a price control, because everyone can get a policy at roughly the same price.

In a traditional health insurance market, insurers base their rates on a variety of demographic and underwriting factors that estimate the amount of risk each individual brings to the pool. Rates may vary based on age, gender, geographic location, health status and other factors. Rate variations are used both to attract the largest number of people to the pool and to keep the pool representative of the health of the general population. While this variation keeps the rate lowest for the healthiest individuals, low-risk individuals also subsidize the rest of market and keep costs lower for the overall pool.

Community-rated states restrict the ability of an insurer to price health insurance based on the risk an applicant brings to the pool. This forces younger, healthier people to pay more, which lessens their perceived value of insurance and leads many to forgo insurance. When younger and healthier people choose not to enter the pool, premiums escalate for those who do have coverage. Eventually, the premiums are so high that the only individuals left in the pool are those too sick to obtain more affordable coverage.

In 1992, New York passed legislation applying both community rating and guaranteed issue to health insurance policies issued statewide. Before the law was passed, a 55-year-old healthy male paid about twice what a 25-year-old healthy male paid for a policy.

After the law was implemented, the rates for the 25-year-old man jumped more than 60%. Faced with this kind of rate hike, younger people dropped out of the health insurance market. The health insurance "death spiral" started, and within a few years everyone was paying far more than before the law was passed.

SOLUTIONS: States that have adopted community rating must return to risk-rated premiums. Even New Jersey, the1990s poster child for community rating, authorized a new plan in 2002 that permits broad rate bands. In states where elimination is not politically feasible, moving to modified community rating that permits some underwriting is an option.

Discount Medical Plans

Non-insurance plans that provide a discount on medical, prescription drug and dental services, as well as other health-related products and services.

With the increasing uninsured rate and the popularity of consumer-driven initiatives (like Health Savings Accounts, or HSAs), consumers are more price-sensitive and want to make sure they are getting value for their health care dollars. Discount health plans can provide significant savings for routine care, prescription drugs, vision and dental services, and in some cases physician visits and even surgery. Discount cards may be an uninsured consumer's only way to access affordable care.

It is important to note that discount health plans are not insurance products—a fact missed by some regulators. Discount health plans do not share risk, include cost sharing arrangements, exclude pre-existing conditions, or determine benefits. However, a number of policy-makers—including the NAIC—have proposed to regulate discount health plans with insurance-based concepts like solvency standards and rate review. Inappropriate regulation will discourage discount cards from being sold in a state and impede consumers' ability to get access to discounted products and services.

SOLUTIONS: Discount plans will be increasingly valuable in the future as we see the rise of consumer-driven health plans. State legislators should consider common-sense standards, such as a registration requirement, disclosure that the discount plan is not health insurance, and other necessary disclosures that discourage fraudulent vendors. Those actions will protect consumers and ensure the availability of discount cards.

Proposed legislation should also consider the impact on other existing health insurance arrangements such as PPOs. PPOs, which offer discounted health care to insurers and their members, may inadvertently fall under discount medical plan definitions, leading state legislators and regulators to try to regulate them as such. But they are quite different and should be kept separate.

Exclusionary or Medical Waivers (Riders)

A contract amendment in which an individual agrees to waive coverage for a specific medical condition. Used exclusively in the individual market, the waiver allows the applicant to still obtain coverage for all other medical conditions.

For most people, obtaining health insurance is easy. Most applicants are issued coverage without any increase in premium or without imposing a medical waiver. Individuals who have medical conditions may

have a more difficult time finding coverage—especially those with relatively minor but potentially costly medical ailments. They are typically either faced with substantially increased premiums or denied coverage.

Exclusionary riders provide individuals with another coverage option. Certain medical conditions, like allergies, can be expensive to cover but do not result in other health problems. An exclusionary waiver, or rider, on a health policy allows the applicant to waive coverage for the condition in exchange for coverage for all other health problems. If an applicant declines the policy with a rider, he or she can still apply to other insurers or—if available—to the state's high-risk pool. These are the same choices applicants would have if the state prohibited riders.

In most states, insurers may offer either temporary or permanent medical waivers. But some have prohibited the practice. Louisiana tried to exclude medical waivers for a period of time. Finding that this did more harm than good, lawmakers voted almost unanimously to reinstate the use of exclusionary medical waivers.

Reports issued by the National Association of Health Underwriters (NAHU) and the Council for Affordable Health Insurance (CAHI) debunk the perception that affordable health care is not available to persons with chronic conditions. In some cases an applicant may spend less money accepting a policy with a rider and paying for the non-covered care out of pocket. For example, one simulated applicant in the NAHU report received offers that limited coverage for her allergies. The lowest monthly premium offered with a rider was $111, and the projected average cost of her allergy medicine was $31 per month, amounting to an effective monthly cost of $142. The average monthly premium without a rider was $257.

SOLUTIONS: Quite simply, medical waivers provide an additional option to those having difficulty finding insurance. State legislators and regulators should permit the issuance of exclusionary riders in individual health insurance policies.

Government-Run Pools

Any of a number of proposals that create government pools that compete with the private market. Typically, state governments allow their plans to have more favorable rules (like providing mandate-free health insurance policies) and provide a state subsidy. Examples of some pools are listed below:

Dirigo Choice/Healthy Illinois (proposed)—After Maine destroyed the individual market with community rating and guaranteed issue, policy-makers decided even more government intervention would be the answer. Maine created a complicated, government-subsidized health insurance plan targeting the uninsured, especially those in small businesses. By most objective accounts, the plan has been a disaster. Despite burning through millions of dollars, the plan has only been able to attract 2,300 uninsured. In order to keep the plan going, Maine will be taxing the private market, claiming the plan has saved the health care and health insurance industry more than $40 million. Nevertheless, several groups in Illinois are proposing Healthy Illinois, which would allow the state to negotiate premiums for a pool combining small businesses, self-employed people and individuals.

Healthy New York—New York also destroyed its individual insurance market with guaranteed issue and community rating. And as a result, New York's health insurance became unaffordable for all but the richest New Yorkers. In response, policy-makers created Healthy New York, which requires HMOs to provide guaranteed issue, community-rated health insurance. In order to ensure the coverage was affordable, the state agreed to provide a subsidy to insurers for losses and allowed them to sell mandate-light insurance plans. Despite these advantages and the losses incurred by the health insurance carriers, Healthy New York has attracted merely 70,000 members—less than .4% of the population.

SOLUTIONS: Before increasing government interventions, states should try proven market-based solutions. Despite the best evidence that community rating and guaranteed issue do not work, states continue unwisely to keep these market-killing "reforms" in place. Passing market-based reforms such as high-risk pools, reducing the regulatory burden and ensuring that residents have access to consumer-driven options such Health Savings Accounts will provide the uninsured with affordable options and won't destroy the insurance market.

Guaranteed Issue

Requires insurers to accept applicants regardless of their health status.

Requiring insurers to accept every application for insurance regardless of the risk creates what is known as "adverse selection." As a result, people forgo insurance coverage when they are in good health and purchase it when they are sick. The pool gets smaller and the insurance more expensive because healthy people never join the pool or drop out when the cost exceeds their risk.

Supporters of guaranteed issue say it is necessary to make coverage accessible to those who need it most. This is not true. State-sponsored high-risk pools are the best way to make coverage accessible to the medically uninsurable.

Guaranteed issue legislation leads to some very predictable outcomes. Legislation passed in the early 1990s in several states has destroyed their individual markets. The passage of guaranteed issue was made worse in a number of states because it was implemented in conjunction with community rating. The coupling of these two concepts has driven numerous insurance carriers out of the market, and increased insurance premiums beyond the reach of all but the wealthy.

When New Jersey's guaranteed issue legislation became effective in 1994, a family policy (known as "Plan D") with a $500 deductible and a 20% copayment (i.e., the insurer pays 80%) cost as little as $463 a month and as much as $1,076, depending on which of the 14 participating insurers the family chose.

By November, 2005, that same policy purchased from one of the 10 remaining companies cost between $4,070 (Oxford Health Insurance Company) and $21,992 (Celtic) *per month* — that's $48,849 to $263,904 per year.

In Kentucky, guaranteed issue and community rating rules adopted in 1994 required insurers to offer a limited number of state-designed, standardized health plans. As a result, 45 insurers abandoned the state,

leaving only Anthem Blue Cross, Humana in a limited capacity and Kentucky Kare, the state-run plan (now Kentucky Access, a high-risk pool). Legislation passed in 2000 and 2005 to reform the reforms have encouraged a number of insurers to return, but premiums are still above average and Kentuckians still have relatively few choices.

SOLUTIONS: Guaranteed issue is a politically inspired "solution" to the problem of the uninsurable. States have more than a decade of experience that proves this solution exacerbates the problem of access to affordable health insurance coverage. It is vital that state legislators, in attempting to ensure access to coverage for the 1% to 2% of the population that is medically uninsurable, not destroy the health insurance market for the other 98%. The only real solution is to pass a high-risk pool [see below], which creates a true and affordable safety net for those who need coverage.

Health Savings Account

The replacement for and expansion of Medical Savings Accounts (MSAs). Health Savings Accounts (HSAs) became available for everyone under age 65 on Jan. 1, 2004.

The HSA allows employers or employees to contribute pre-tax dollars into a personal savings account from which to pay medical expenses. HSA funds will not be taxed as long as they are spent on qualified medical expenses. HSAs must be linked to a high-deductible medical plan (minimum deductible is $1,050 for individuals or $2,100 for a family in 2006, but this amount will be adjusted by the federal government annually).

SOLUTIONS: States that have first-dollar mandates (i.e., mandates that require payment before the deductible is met) should repeal them in order to ensure that HSA-qualified plans are available in the state. States should also ensure that their tax codes mirror the federal tax code — including deductions for the account. Finally, because state government is the largest purchaser of health care, offering an HSA option to state employees, the high-risk pool and even Medicaid will greatly reduce a state's health care costs.

[*Note:* CAHI has posted its "HSA State Implementation Report," which tracks HSA legislation in the states, available at www.cahi.org.]

High-Risk Pool

A state-run plan that provides comprehensive health insurance to the 1% to 2% of the population that is medically uninsurable.

High-risk pools have been around for more than 25 years, and in 2005 they covered more than 180,000 people in 34 states. They are the social safety net for the uninsurable, providing access to health coverage for some of the society's most vulnerable. High-risk pool members typically have serious medical conditions and do not have access to guaranteed issue insurance coverage, which is required in the small group or large group markets.

High-risk pools are a win-win proposition. Health insurers, which usually help fund risk pools, are able to more accurately predict and spread risk and keep costs down. The uninsured find that health insurance rates become more affordable. And, most importantly, individuals with health conditions are able to obtain high-quality (and often lower-cost) health insurance.

Since providing coverage is costly, most successful high-risk pools are funded through a partnership with high-risk pool members, state government, health insurers, and health care providers. Typically, the high-risk pool members pay between 125% and 200% of the standard insurance rates — far less than what insuring their conditions would actually cost. Even so, premiums do not cover claims. So insurers are assessed for the pool's losses — usually based on their share of the insurance market — to make up the difference. In addition, state governments typically supply some funding from state revenues. Finally, health care providers discount the care received by high-risk pool members.

The missing piece in the puzzle is federal funding. The federal government has provided funding for both the operation and start-up costs of risk pools in the past. At the writing of this Guide, funding has been passed by both the Senate and the House, but has not been enacted.

SOLUTIONS: Every state that does not have a high-risk pool should be attempting to start one. Those that have relied on guaranteed issue as a safety net for the uninsurable should eliminate it and establish a high-risk pool instead. Those that already have pools should encourage Congress to continue and expand funding for state-run high-risk pools.

List Billing

A billing process that consolidates individual health insurance bills, usually done in conjunction with an employer. Employers agree to deduct 100% of the individual health insurance premiums from the employees' checks, which is then remitted to the insurer.

Purchasing health insurance can be an intimidating process. Some employers that do not offer health insurance have decided to make the process easier for their employees by approving the "list billing" procedure. Typically the company will invite an insurance agent to discuss plan options with interested employees. Once the insurer has accepted the applications for individual insurance, the employer receives a monthly bill listing the premium for each individual/employee policy. The employer, in turn, deducts the premium from the insured employee's checks.

Critics fear that employers will abandon the group insurance market for individual (i.e., personally owned) coverage. This concern misses the point entirely. These plans are typically sold to employees of companies that do not have a group benefit plan, and the only available coverage option for individuals is in the individual market. It is also important to note that individuals who leave a company can keep their coverage, provided they continue to pay the premium.

SOLUTIONS: List billing certainly does not solve all the problems of the uninsured. However, it can be an important tool to make the purchase of insurance easier, and if combined with a Section 125 plan (a plan that allows certain expenses to be deducted on a pre-tax basis) or a Health Savings Account, it can make coverage even more affordable.

Mandated Benefit

State law requiring that a health insurance policy or health plan cover (or offer to cover) specific providers, procedures or benefits.

As reported in CAHI's report "Health Insurance Mandates in the States" (available at www.cahi.org), the number of mandates has swollen over the past 40 years

to more than 1,800. While mandates may make health insurance more comprehensive, they also make it more expensive. In certain states, mandated benefits have increased the cost of individual health insurance by as much as 45%. When health insurance costs increase, more people drop or decline coverage.

According to a 1999 study conducted by the Health Insurance Association of America (now America's Health Insurance Plans), as many as one in four individuals who are without coverage are uninsured because of the cost of state health benefit mandates. At a time when consumers are counting every dollar, it is important to recognize that there is a cost to the consumer who is required to purchase a benefit he or she may never want or use. That cost may be the determining factor in whether or not the consumer can afford health insurance. Because legislators have saddled health insurance plans with so many mandates, the choice for many people is Cadillac coverage that's loaded with benefits or no coverage at all.

For more information on mandates, including definitions and a current list of mandates nationwide, please visit CAHI's website at http://www.cahi.org/cahi_contents/issues/mandates.

SOLUTIONS: Before a state legislature passes a new mandate, it should require a comprehensive cost analysis to assess the mandate's likely impact on health insurance premiums. And before imposing it on the whole citizenry, the state should include the mandated coverage in state workers' policies. (See ALEC's model legislation for more detailed information.)

States should also consider making available mandate-free policies, as Arkansas, Colorado, Florida, Montana, North Dakota and Utah have done. Such policies would be much more affordable and would give consumers the peace of mind that comes with knowing they will not be bankrupted by an unforeseen event.

These plans can translate into real savings for employers. For example, the Billings Gazette reports that New West Health Services will offer a bare bones health insurance plan in Montana that will save 75% over conventional health insurance plans. The pilot program, passed by the Montana Legislature in 2003, limits enrollment to only 1,000 residents. Seven other states also introduced legislation authorizing plans that limit mandated benefits. Colorado passed its version of the legislation in early 2003.

Market Conduct/Self-Audit

A market conduct examination is the review of insurance company operations by regulators. A self-audit is the comprehensive review of a company's compliance with existing laws by the company itself.

Even though the vast majority of health insurance companies comply with existing laws and regulations, it is important for regulators to be able to verify their compliance and to find the companies that may be skirting the law. Comprehensive market conduct examinations can reveal many compliance problems and ensure a company's compliance with all applicable laws.

Unfortunately, market conduct examinations can also be expensive and disruptive. Space, materials and information must be provided to the examiners. Many states contract with outside examiners to provide these services, which further add to the companies' cost.

Companies that have more than one of these examinations being conducted at the same time may find their costs of compliance exploding.

A comprehensive self-audit can be viewed as both an alternative to more frequent market conduct examinations and an additional tool to ensure company compliance with legal and regulatory requirements. Companies that regularly conduct self-audits can catch compliance problems sooner and correct them faster than by finding them on a case-by-case basis or waiting until the next market conduct examination.

SOLUTIONS: Regulators who have unfettered discretion to require market conduct examinations can create more problems than they solve. A more workable plan is for legislators to support the efforts by NCOIL and the NAIC to limit the number of duplicate market conduct examinations in a year, and instead focus on targeted market conduct examinations that may deal with only one subject.

Health insurers should also be encouraged to police themselves with comprehensive self-audits. Self-audit legislation provides a win-win for consumers, regulators and the industry. The companies are able to do a comprehensive analysis of their compliance without providing a blueprint for plaintiffs' attorneys, who may want to conduct a class action lawsuit, and they can have any problems corrected early. As a result, regulators could and should focus their efforts on companies that have consistent problems.

Medicaid Health Savings Accounts

HSAs combine a high-deductible health insurance policy (HDHP) with a savings account. The high-deductible policy protects the insured from the cost of a catastrophic illness, prolonged hospitalization or a particularly unhealthy year. The savings account is controlled by the insured and is intended to pay small and routine health care expenses. (See Health Savings Accounts above for a fuller explanation of how regular HSAs work.)

Medicaid is the federal-state program that provides health insurance, long term care and other health care services to about 52 million poor, disabled and senior Americans. For the first time since Congress passed it in 1965, Medicaid has become more costly than Medicare and is the largest budget item in nearly half the states.

Can HSAs help the Medicaid program? For at least some of the Medicaid population, the answer is yes, but the savings will likely be relatively small given the size and scope of the Medicaid program. The problem with the Medicaid program as it is currently structured is that people have little incentive to be prudent shoppers of medical services. A Medicaid HSA plan could change those incentives and save the program money over the long term.

Iowa and Florida have already incorporated HSAs into their Medicaid programs, and South Carolina is trying (at this writing).

SOLUTIONS: States should consider adding an HSA to their Medicaid program. The state could continue to be the insurer, but increase the deductible, depositing part or all of the savings in the Medicaid beneficiary's HSA. Or, the state could simply provide a defined

contribution to a private sector insurer or third-party administrator selling HSA plans.

Would this approach be a radical departure from traditional Medicaid programs? Yes, but Medicaid needs radical change in order to sustain the program. Some considerations when designing an HSA Medicaid plan:

- What should happen to the HSA balances once a Medicaid beneficiary leaves the program?
- Can states use methods such as electronic benefit transfer (EBT) cards to protect against misuse of the account as they do with their food stamp programs?
- Should a Medicaid HSA program be implemented as a limited demonstration project to test and evaluate it (as Florida has done)?
- Since HSA plans already include a financial incentive to use the funds wisely, would frequently used state cost control restrictions such as prescription drug lists and formularies that limit patient choice also be imposed on the Medicaid HSA population?

Medical Malpractice Reform

Efforts to limit the size of punitive damage awards or to require arbitration, which would reduce the cost and increase the availability of malpractice and health insurance.

The United States has become the most litigious society in history. The Towers Perrin Tillinghast annual report pegs U.S. tort system cost at about $246 billion in 2003, a 5.4% increase over 2002, which experienced a 13.4% increase over 2001.

Some efforts at reforming the tort system have been successful. Building on these reforms could produce billions of dollars in savings throughout the health care system.

Even more importantly, a 2004 report by the Pew Charitable Trusts Project on Medical Liability indicates that there is a link between liability concerns and the quality of care delivered by physicians and hospitals. In states without liability reform, doctors had a higher tendency toward dissatisfaction in their profession, which affected the care they delivered and limited their investment in new technologies.

Many states adopted provisions intended to contain the rise in malpractice premiums by limiting the volume of malpractice litigation and the size of malpractice awards. Some states passed laws shortening the statute of limitations for malpractice claims; others imposed ceilings on the amount of attorneys' fees recoverable as a result of malpractice actions. Some states imposed damage caps, some on non-economic damages only, others on pain and suffering awards and still others on both.

Some of these efforts have been very successful. For example, the *St. Petersburg Times* reports that First Profession Insurance Co. lowered its premium rate increase for 2004 from 18.6% to 8% after passage of Florida's medical malpractice reform bill. However, the problem of frivolous lawsuits brought by trial lawyers remains. Further, under scrutiny in the courts some early reforms have been found wanting.

SOLUTIONS: The Pew study demonstrates that reducing medical liability costs not only affects health care costs, but also may improve patient care. Legislators should consider following the example of California's 1975 Medical Injury Compensation Reform Act

(MICRA), which among other reforms limits non-economic damage awards to $250,000 and limits contingency fees charged by trial lawyers. Florida, New Jersey, Ohio, Texas, West Virginia, Nevada, Mississippi and other states have recently passed significant tort reforms, and in some cases success has been immediate. For example, the AP recently reported: "The Medical Assurance Co. of Mississippi, which provides medical malpractice insurance to about 60% of the doctors in the state, will not raise base premium rates in 2005."

Legislators might also require arbitration before litigation. The National Arbitration Forum has suggested language for such a requirement. Research by the American Bar Association indicates that arbitration can save as much as 95% of the cost of a lawsuit. While 54% of individual plaintiffs win their lawsuits, as many as 70% of individual claimants win their arbitration cases. Requiring arbitration as a condition precedent to filing a lawsuit could be a win-win situation for consumers, insurers, medical practitioners and lawyers.

Finally, legislators might consider that in Nebraska punitive damages awarded in malpractice suits are directed to the state's education fund. Might not such monies also be usefully directed to a state's high-risk pool to cover the state's uninsured?

Pay or Play Law

A state or federal requirement that an employer or individual purchase health insurance or pay an additional fee (or tax).

"Pay or play" laws require employers to provide a state-defined minimum level of health insurance coverage, which is usually a very rich benefit plan, to their employees. If they choose to provide the coverage, they must pay at least a minimum percentage of the cost of the plan (California legislation requires employers to pay 80% of the plan's cost). Employers who choose not to provide health insurance coverage are required to pay a new tax to the state. The tax money is meant to offset the state's costs for creating its own state-run benefit plan for uninsured workers.

Supporters believe pay or play laws meet the twin goals of achieving universal coverage and preserving the private market. However, a substantial bureaucracy is required to create a state-run health plan, monitor employers, review all health insurance plans for minimum standards and sign up the uninsured. Opponents believe this is the first step in a government-run universal health scheme.

SOLUTIONS: Better approaches include providing tax credits for individual health coverage, providing a list billing option and passing legislation to allow the sale of low-cost, mandate-free plans. These approaches better target the low-income uninsured and make insurance more affordable for small employers.

Preferred Provider Organizations/Rental Networks

Preferred Provider Organizations (PPOs) provide access to discounted medical care to insurers, employers, plan members, and sometimes to discount medical plan members. Health care providers agree to discounted rates in order to attract new patients.

PPOs have been providing access to discount medical care for more than two decades. They serve as an intermediary between health care providers and insurers. Health care providers agree to provide discounted medical care in exchange for various

contract terms, often including faster claims payment, and access to new patients. Health insurers seeking access to these discounts agree to the contract terms and pay an access fee to the PPO.

This service has worked very well for most doctors and patients. However, in the 1990s, physicians sought the contracting advantage of unionization. By collectively bargaining, physicians hoped to increase their reimbursement rates. Largely unsuccessful in their efforts, physicians — and the American Medical Association — are targeting "managed care reform." In their lexicon, managed care reform means more favorable contracting terms governed by legislative action. For example, physicians are seeking to limit the kinds of companies that are allowed to access the discounts, as well as a requirement that every new contract must be approved by every physician (a logistical impossibility).

SOLUTIONS: The rules proposed by the American Medical Association should be considered carefully. The AMA proposal could cripple the ability of consumers to access the discounts provided by PPO networks and could eliminate the new discount medical plan industry.

Prompt Pay Laws/ Clean Claims Laws

See Clean Claims discussion above.

Rate Bands

Rate bands limit the ability of insurers to underwrite — that is, to increase or decrease rates for health conditions, which means that younger and healthier people will be charged more and older and sicker people will be charged less than their true risk.

Limits on a carrier's ability to underwrite in the large group market (usually more than 50 medical lives) and the individual market are rare. In the small group market (usually 2-50 medical lives, as defined by HIPAA), most states have adopted some limits, usually referred to as a "rate band." Very few states have adopted either community rating (or "modified community rating"), which eliminates underwriting or unlimited underwriting (no rate band). The most commonly adopted standard is the NAIC model, which allows carriers to increase or decrease rates by 25% from the base rate.

Unfortunately, the popular perception is that narrowing rate bands (limiting them to a smaller range) leads to either overall rate reductions or rate reductions for some segment of the population. Nothing could be further from the truth. As demonstrated in *Destroying Insurance Markets: How Guaranteed Issue and Community Rating Destroyed the Individual Health Insurance Market in Eight States* and other studies, narrow rate bands inevitably lead to higher overall insurance rates. An even greater concern is that the higher rates caused by rate bands disproportionately fall on the young, healthy and relatively poor. In the end, markets fall into a death spiral — fewer insured persons in the pool with higher overall health costs.

SOLUTIONS: The failure of this government-imposed "solution" typically leads to recriminations against the insurance industry and calls for further government intervention. States could look to the 1991 NAIC model with a rate band of +/-25% as a compromise standard, but understand that a broader rate band will yield lower overall insurance premiums, and decrease the number of uninsured. Broader rate bands lead to a

healthier insurance market, increase the availability of insurance coverage, and ensure the coverage remains affordable.

Single-Payer System

A health care system in which taxes are collected so that a government agency can pay all covered medical claims. Canada's health care system is often cited as a model the United States should follow. Currently, the U.S. Medicare program for seniors operates like a single-payer system, as does the federal-state Medicaid program for the poor.

Since 1992, several states have considered adopting a single-payer system, and some have passed enabling legislation, but none has been able to implement the program. In the November 2002 elections, Oregon voters rejected a state-based single-payer plan by a 4-to-1 margin. Illinois also considered a single-payer plan, and Maine has implemented its Dirigo Health plan, a scaled-back version of a single-payer system that is already meeting much higher-than-expected costs and falling interest.

The biggest problem facing states considering moving to a single-payer system is implementation. Federal law supersedes state law, and about half of the employees who get health insurance through the workplace are in self-funded ERISA plans. The federal government, not the states, has authority over those policies. In addition, seniors in the federal Medicare program are outside of state law. Thus, there are simply too many people whose health insurance plans are outside of state control to create an effective state-based single-payer system.

SOLUTIONS: The vast majority of people in every state have health insurance coverage. States should look at the populations that are chronically uninsured and devise an affordable, achievable solution for them.

Speed to Market

Proposals that streamline the regulatory environment to make it easier for companies to market new and existing products.

As the state regulatory environment has become increasingly complex and difficult to navigate, insurers have sought solutions to simplify this process. In some cases, states have streamlined their filing requirements, but in many others it may take months for rate and form filings to be completed. The extended time needed to complete the filing requirements can result in significant financial hardships for carriers while slowing consumers' access to new options. Carriers and regulators have proposed numerous solutions to this problem, including:

1. **An optional federal charter** — An optional federal charter would allow a carrier to file any required rates and forms with the federal government. Once approved, the plans would be available in all states.
2. **Interstate compact** — The interstate compact creates a new multi-state association (created and governed by states that join the compact) that would become responsible for reviewing filing based on agreed upon rules.
3. **Health Care Choice Act** — This federal proposal would allow individuals to purchase health insurance plans being sold in other states. Once one state approved the rates and forms of a company's

plan, the plan could be marketed in all 50 states (assuming availability of provider networks, if applicable).

4. **State Modernization and Regulatory Transparency Act (SMART Act)** — The act, also known as Oxley-Baker, creates new limits on state regulatory authority, making the regulatory environment more predictable for companies.

5. **Market harmonization** — Congress has proposed a few versions of market harmonization in this past year. The proposals attempt to create a health insurance environment similar to the proposed Health Care Choice Act, but with certain minimum standards. Opponents have opposed such proposals on two grounds. First, there is concern with state preemption (i.e., the federal government overriding state health insurance laws). The second is concern that the federal minimum standards will eventually lead to market-killing reforms similar to those passed in New Jersey and New York.

SOLUTIONS: While state legislators should monitor these federal and NAIC proposals, it is also important that state legislators closely examine their own markets, asking such questions as:

- Does the state have a large number of carriers selling insurance in the market?
- Are carriers entering or exiting the market in large numbers?
- Are there a variety of plan options, including HMO, PPO, HSA and indemnity plans?
- Do insurance companies view the regulatory environment as fair?
- Do insurance companies view the regulatory environment as professional and efficient?

If the answer to any of these questions is no, it might be worth the time to look at the feasibility of reform.

Tax Credits

A bipartisan initiative to provide individuals and families with refundable, "advanceable" tax credits to purchase health insurance.

Federal tax credits were enacted on a limited basis in 2003 for displaced workers. The Bush administration is considering broader legislation that would make credits available to the 46 million Americans currently without health insurance.

In 2001, Mark V. Pauly and Bradley Herring published an article in the journal *Health Affairs,* which concluded that a "fixed-dollar" tax credit (i.e., pays a flat amount regardless of a person's age, income or cost of a chosen policy) "targeted toward a more comprehensive plan could cut the proportion of uninsured by a third to two-thirds . . . ."

SOLUTIONS: Several states already have passed limited tax credit legislation. State legislators should work to supplement any federal tax breaks enacted in Congress. In addition, state legislatures should call on Congress to authorize a broader system of tax credits immediately.

Underwriting

A process by which an insurer determines whether or not, and on what basis, it will accept an application for health insurance coverage, along with how much premium to charge the applicant based on the risk the person or group brings to the pool.

Insurance, by its very nature, assesses risk. Distinctions among those applying for coverage are drawn to permit the accurate pricing of the insurance protection sought. Identification and actuarial analysis of factors such as age, geographic location, health status and lifestyle choices permit insurance companies to charge appropriate and generally lower prices for health insurance coverage.

Underwriting is important for three reasons. First, it is the only way to properly assess how much a person should pay. Without it some people are undercharged while others are overcharged. In addition, underwriting forces people to take responsibility for their actions. While many medical conditions arise through no fault of one's own, others are a direct result of lifestyle and personal choices. Finally, underwriting helps to keep prices low for those who are likely to have the fewest claims. These people, estimated to comprise more than 65% of the insured population, help to subsidize the rates for those with serious medical conditions.

SOLUTIONS: Laws that severely limit underwriting should be rejected. States may also want to commission a study comparing health insurance rates and availability in states with underwriting and states without it.

Glossary of Insurance Terms

Adverse Selection: The tendency for people with greater needs to be more likely to sign up for insurance, or to enroll in one plan over another, resulting in a health insurance pool containing a disproportionate share of people with medical conditions. Such a situation leads to higher premiums, which will drive healthier people out of the pool.

Ambulatory Care: Medical services provided on an outpatient (nonhospitalized) basis. Services may include diagnosis, treatment, surgery and rehabilitation.

Ancillary Services: Health care services conducted by providers other than physicians and surgeons. These services can include such services as physical therapy and home health care.

Annual Benefit: Maximum amount paid for specific medical services or total medical services in one year.

Assignment of Benefits: The practice of a beneficiary instructing an insurer to pay benefits directly to the provider of services.

Balance Billing: The practice when medical care providers (such as doctors, hospitals or other medical practitioners) bill the insured for the portion of the bill not paid by the insurer. The practice is prohibited by Medicare and some managed care companies.

Beneficiary: The person entitled to receive benefits under a plan, including the covered employee and his or her dependents.

Benefit: Amount payable by the insurance company to a claimant, assignee or beneficiary when the insured suffers a loss.

Claim: Demand on the insurer by an insured person for the payment of benefits under a policy.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985): A federal law that requires employers with 20 or more employees who offers health insurance to allow eligible employees leaving the company (and their covered dependents) to continue their coverage, usually for up to 18 months, if the employees pay the premiums (up to 102%) themselves.

Community Rating: The idea that an insurer should charge every insured the same premium regardless of age, gender, geographic location or health status.

Conversion Privilege: A contractual right given to an insured person whose group coverage terminates so that person is able to convert to an individual policy without providing evidence of insurability.

Coordination of Benefits (COB): Method of integrating benefits payable under more than one health insurance plan so that the insured's benefits from all sources do not exceed 100% of allowable medical expenses or eliminate incentives to contain costs.

Copayment: Usually a fixed-dollar amount an insured is required to pay to receive services, i.e., $10 for a doctor's visit, $15 for a prescription.

Co-insurance: Most policies require the insured to pay some portion of the health care bills. A typical arrangement is that the insurer pay 80% and the insured 20%, up to $5,000 out-of-pocket. After hitting the maximum out of pocket limit, the insurance company pays 100% of covered expenses during the remainder of the calendar year, up to any maximum limits of the policy.

Cost Shifting: The shifting of health care costs from those who are uninsured or whose insurers pay very little (such as Medicare) to other payers, usually those who don't have the advantage or large managed care or government-negotiated discounts.

Covered Expense(s): An expense that will be reimbursed according to the terms of the plan or insurance contract.

Deductible: The amount of covered expenses that the insured must pay before a plan or insurance contract starts to reimburse for eligible expenses.

Duplication of Coverage: Coverage under two or more policies for the same potential loss. (see also, Coordination of Benefits)

Eligible Expense(s): The portion of a health care provider's services that are covered for payment under the terms of the health plan or insurance contract.

Employee Retirement Income Security Act of 1974 (ERISA): A federal law that originally set minimum standards for funding, vesting and termination of employer-sponsored pension and health benefits plans. ERISA applies to all employers, except church and government employers. Importantly, ERISA preempts all state laws that "relate to" an employee welfare benefit plan. But it "saves" from preemption those state laws that regulate the business of insurance, and it "deems" that an employer providing benefits is not in the business of insurance. Large employers are advantaged ONLY because they are better able to self-fund and bypass using an insurance company for their benefits.

Evidence of Insurability: A procedure used to review factors concerning a person's physical condition and medical history. From this information, the plan or insurance company evaluates whether and at what rate the applicant can be offered coverage. (see "Underwriting")

Exclusionary Medical Waiver (Rider): An amendment to insurance contracts limiting or excluding coverage for certain medical conditions. For example, an insurer might place a rider on the policy of an applicant with hypertension, excluding payment for high blood pressure drugs.

Experience Rating: Process of determining the premium rate for a group based wholly or partially on that group's claims experience.

Explanation of Benefits (EOB): A document sent to an insured when the plan or insurance company handles a claim. The document explains how reimbursement was made or why the claim was not paid. The appeals procedure should be outlined to advise the insured of his/her rights if there is dissatisfaction with the decision.

Fee Schedule: A method of paying benefits that relies on a fixed-dollar amount for each service rendered.

Fee-for-Service Reimbursement: Method of payment for each visit or service rendered. Unlike a Fee Schedule, FFS payments may vary according to a provider's own charges or through a "Usual, Customary and Reasonable" standard of payment.

Flexible Spending Accounts: Special accounts authorized under Section 125 of the Internal Revenue Code and typically funded by an employee's salary reduction to help pay certain expenses not covered by the employer's plan or insurance contract. Because FSA deposits escape federal income taxes, participants can pay for medical care with pretax dollars, but they forfeit any unused funds at the end of each calendar year.

Gatekeepers: Usually a primary care physician in an HMO who determines the patient's access to further treatment and specialists.

Group Insurance: Policies sold to more than one person, usually at the place of employment.

Guaranteed Issue: The requirement that insurers accept all applicants regardless of their health status.

Guaranteed Renewable: The requirement that insurers renew a policy at the end of a specified time if the insured chooses to do so.

Health Alliances: Health Alliances, or Health Insurance Purchasing Cooperatives (HIPCs), are state-sanctioned entities whose primary purpose is to negotiate with health plans to provide coverage at competitive prices to members of the alliance.

Health Insurance Purchasing Cooperatives (HIPCs): See Health Alliances.

Health Maintenance Organization (HMO): An organization that provides a wide range of comprehensive health care services for a specified group of enrollees for a fixed, prepaid premium. There are several models of HMOs: Group Model, Individual Practice Association (IPA), Staff Model and Network Model.

Health Insurance Portability and Accountability Act (HIPAA): A 1996 law intended to make employer-provided health insurance more "portable" by allowing continuously covered employees leaving a company to get coverage from a new employer or in the individual market without having to wait through an exclusion period. HIPAA also established guaranteed issue in the small group market and included a Medical Savings Account demonstration project.

Hospital Indemnity Insurance: Health insurance that provides a stipulated daily, weekly or monthly payment to an insured person during hospital confinement, without regard to the actual accrued expenses.

Hospital Medical Insurance: Coverage that provides benefits for the cost of any or all hospital services normally covered under various health care plans.

Indemnity Insurance: Health insurance policy that pays predetermined benefits to the insured for covered services. In essence, the insured is "indemnified" for a loss. Traditionally, the insurer pays on a fee-for-service basis and plays no role in the actual delivery of health care services.

Individual Insurance: A policy purchased by the insured which provides protection to the policyholder and/or family members. Also referred to as the "individual market."

Induced Demand: Similar to "moral hazard," this is the idea that once someone is insured, he will be more likely to consume possibly unneeded medical services or products because the insured pays little or nothing for the services.

Insurance: Risk management plan that, for a price, assumes some or all of the insured's risk of serious financial loss if a covered event occurs.

Lapse: Termination of insurance coverage for failure to pay premium.

Lifetime Aggregate or Maximum: The maximum benefit payment provided under an insurance contract. Health insurance policies often carry a $1 million to $2 million lifetime aggregate.

List Billing: The practice of an employer enabling employees to purchase individual insurance coverage and paying for it themselves through payroll withholding, with the employer simply acting as a conduit for those premium payments.

Loss Ratio: The ratio of claims to premiums (claims divided by premiums).

Major Medical Expense Insurance: Insurance that provides benefits for most types of medical expenses up to a high maximum benefit. Such contracts often contain internal limits and usually are subject to deductibles and coinsurance.

Malpractice: Unprofessional, incompetent or inappropriate medical care.

Managed Care: Health care delivery arrangements that are designed to control health care costs and improve utilization of services.

Medicaid: State programs, supported by federal matching funds, that provide health insurance and other public health assistance to qualified low-income persons.

Medical Necessity: Term used by insurers to describe medical treatment that is appropriate and in accordance with generally accepted standards of medical practice.

Medicare Part A (Hospital Insurance): Federal health insurance program primarily for seniors age 65 and over that covers medically necessary inpatient care in a hospital, skilled nursing facility or psychiatric hospital, and for hospice and home health care. The program is funded by a 2.9 percent payroll tax.

Medicare Part B (Supplemental Medical Insurance): Federal health insurance program primarily for seniors age 65 and over that covers medically necessary physician services and many other outpatient medical services and supplies not covered by Part A. The program is funded by charging participants a monthly premium and by general tax revenues.

Medicare: Federally sponsored program under the Social Security Act that provides hospital benefits and medical care to persons 65 years of age and older and to some younger persons (usually disabled or who have kidney failure) who are covered under Social Security benefits.

Medigap (Medicare Supplemental Insurance): Medigap insurance is specifically designed to supplement Medicare's benefits and is regulated by federal and state law. It must be clearly identified as Medicare supplemental insurance and it must provide specific benefits that help fill the gaps in Medicare coverage.

Mental Health Services: Behavioral health care services that may be provided on an inpatient, outpatient or partial hospitalization basis.

Moral Hazard: The idea that insured persons are more likely to engage in risky behavior or use covered services because they are insured and therefore insulated from bearing the full cost of their actions.

Multiple Employer Welfare Arrangement (MEWA): An employee welfare arrangement designed to provide benefits to employees of two or more employers.

National Association of Insurance Commissioners (NAIC): National organization of state officials charged with regulating insurance. NAIC was formed to provide national uniformity to insurance regulations.

Network Providers: Limited panels of providers in a managed care arrangement. Health plan enrollees may be required to use only network providers or, if allowed to go outside the network, must bear a larger portion of the cost for medical services.

Noncancelable Policy: A policy that can be maintained through timely payment of the premiums until the policyholder decides to change. The insurer may not unilaterally change any provision of the in-force policy, including premium rates.

Non-Network Providers: Noncontracted or unapproved health providers who are outside a managed care arrangement.

Out-of-Pocket Expenses: Those health care costs that must be borne by the insured.

Out-of-Pocket Maximum: The maximum amount that an insured is required to pay under a plan or insurance contract.

Over-Utilization: Inappropriate or excessive use of medical services.

Peer Review: Traditional quality assurance program composed of medical professionals who monitor care and investigate adverse outcomes. The goal of peer review is to find and correct medical practices that do not conform to the standard of care.

Per Diem: Literally, per day. Term that is applied to determining costs for one day of care. It is an average cost and does not reflect true cost for each patient.

Point of Service Plans (POS): An HMO that includes the ability to go out-of-plan to receive services on a case-by-case basis, like a PPO.

Policy: Legal document or contract issued by the insurer to the insured person that contains all the conditions and terms of insurance.

Pool(ing): Used by insurance companies to combine all premiums, claims and expenses in order to spread the risk of insurance coverage.

Portability: The ability of an insured employee to retain his policy after leaving an employer. COBRA also provides a type of portability in that qualified former employees can continue to pay premiums themselves and maintain their insurance for a limited period of time.

Pre-authorization: Previous approval required for a referral to a specialist or non-emergency health care services.

Pre-certification: Utilization management program that requires the individual or provider to notify the insurer before hospitalization or surgical procedure. Notification allows the insurer to authorize and to recommend alternate courses of action.

Pre-existing Condition Clause: A clause in an insurance contract that specifies if benefits will or will not be paid for a pre-existing condition. Additionally, the clause may limit the benefit payable for treatment of pre-existing conditions until a certain time period of coverage has elapsed, usually six months to a year.

Pre-existing Condition: A medical condition or diagnosis which existed (or for which treatment was received) before health insurance coverage began. Serious pre-existing conditions often lead to limited coverage (i.e., medical riders) or denial of coverage.

Preferred Provider Organization (PPO): Managed care arrangement consisting of a group of hospitals, physicians and other providers who have contracts with an insurer, employer, third-party administrator or other sponsoring group to provide health care services to covered persons.

Premium Tax: A state sales tax on insurance premiums.

Premiums: Periodic payment to keep an insurance policy in force.

Reasonable and Customary: The maximum amount a plan or insurance contract will consider eligible for reimbursement, based upon prevailing fees in a geographic area.

Reinsurance: The transfer of part of the insurance risk—along with part of the premium—to another insurer or insurers.

Reserves: A specific amount of money prefunded and set aside to assure adequate funds to cover future claims. Both insurance companies and self-insured employers must "reserve" in order to preserve cash flow and protect solvency.

Retention: The portion of the insurance premium which is allocated for expenses, administration, commissions, risk charges and profit.

Risk Adjustment: Correction of capitation or fee rates based upon factors that can cause an increase in medical costs such as age or sex. In a broader context, it is the attempt to compensate insurers that take on a disproportionate share of those with medical conditions.

Risk: Chance of incurring financial loss by an insurer or provider.

Self-Insurers: Employers, businesses and other entities that chose to directly assume the risk of their beneficiaries (usually employees).

Specified Disease Insurance: Specified disease insurance, which is not available in some states, provides benefits for only a single disease, such as cancer, or for a group of specified diseases. Benefits are usually limited to payment of a fixed amount for each type of treatment.

Standard Risk: Person who, according to an insurer's underwriting standards, is entitled to purchase insurance without paying an extra premium or accept special restrictions.

Stop-Loss Insurance: Protection purchased by self-insured and some managed care arrangements against the risk of large losses or severe adverse claims experience.

Stop-Loss Limit: Also known as an "out-of-pocket limit." A dollar amount the insured must pay before the health plan starts paying 100% of covered expenses.

Subrogation: The practice of a secondary insurer collecting from a primary insurer for claims paid. A health insurer may pay the claims of an insured who is hurt in an auto accident and then "subrogate" against the auto insurance carrier to recover the cost of those paid claims.

Substandard Insurance: Insurance issued with an extra premium or special restriction to persons who do not qualify for insurance at standard rates.

Substandard Risk: Persons who cannot meet the health requirements of a standard health insurance policy.

Third-Party Administrator (TPA): An outside person or firm which provides specific administrative duties (including premium accounting, claims review and payment, arranges for utilization review and stop-loss coverage) for a self-funded plan.

Third-Party Payment: The practice of an insurer paying providers directly for services rendered to an insured, as opposed to an indemnity contract which pays the insured person for the losses incurred.

Trend Factors: The percentage of increase used by an actuary to reflect the projected rise in health care costs overall. Calculation factors also include inflation, utilization, technology and geographic area.

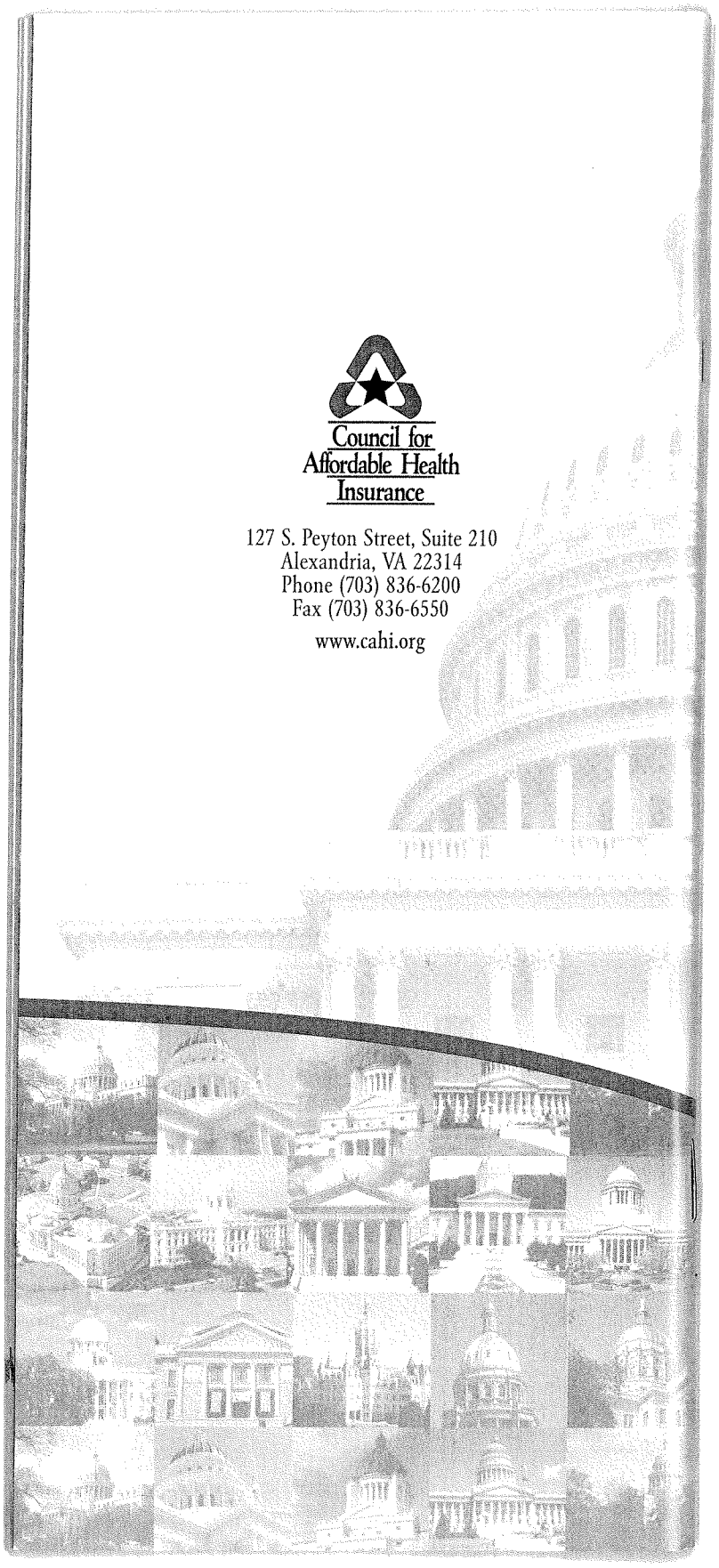
Underwriting: The practice of assessing risk and assigning premiums, on either a group or individual basis. In some cases, it may lead to denial of coverage.

Uninsurables: High-risk uninsured persons whose medical condition(s) precludes them from buying health insurance.

Waiting Period: Time period before one is eligible for benefits.

About the Author

J.P. Wieske is the director of state affairs for the Council for Affordable Health Insurance (CAHI). After graduating from Carroll College with a bachelor's degree in political science and economics, he joined the health insurer American Medical Security, Inc. (AMS), where he started as a claims analyst. Mr. Wieske quickly moved up the AMS organizational ladder to become the senior government affairs specialist in 2001 and later joined CAHI in 2003.



Council for
Affordable Health
Insurance

127 S. Peyton Street, Suite 210
Alexandria, VA 22314
Phone (703) 836-6200
Fax (703) 836-6550
www.cahi.org